DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185012	A. BUILDING _____ B. WING _____	03/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE VILLA CARE AND REHABILITATION CENTER	1600 PRIDE AVENUE MADISONVILLE, KY 42431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual survey and an abbreviated survey (KY #15521) were conducted 03/14/11 throught 03/16/11 to determine the facility's compliance with Federal requirements. The facility was not in compliance with Federal requirements with deficiencies cited at the highest S/S of an "E". KY #15521 was substantiated with deficiencies cited.	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Hillside Villa Care & Rehabilitation Center** does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	F157 The physician for resident # 12 was notified of the event on 1/8/11 by the licensed nurse. The Director of Nursing provided re-education to LPN # 1 on 3/16/11 on change of condition to include physician notification and reporting of events to nursing management. CNA # 1 was re-educated by the Staff Development Coordinator on the procedure for	

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carol L Britt — TITLE: Administrator — (X6) DATE: 04/08/2011

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

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F 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined the facility failed to ensure the physician was notified immediately after an injury requiring physician intervention for one resident (#12), in the selected sample of 15. Findings include: Resident #12 was admitted to the facility on 09/01/07 with diagnoses to include Spinal Cord Injury of C5-C7, Lack of Coordination, Muscle Weakness, History of Urinary Tract Infections, Diabetes Mellitis, Renal Failure, Paraplegia and Morbid Obesity. Review of a nursing note, dated 01/08/11 at 4:30 AM, revealed Resident #12 spilled hot coffee to the abdomen area and redness was noted. The nurse's note also revealed, "Refused for nurse to call anyone". An interview with Resident #12, on 03/16/11 at 3:25 PM, revealed on 01/07/11 at approximately 8:30 PM the resident had requested a cup of coffee be reheated by Certified Nurse Aide (CNA) #1. Resident #12 stated that CNA #1 heated the coffee and brought it back "Scalding hot and I spilled it on my stomach". He/She did not realize the coffee had been spilled because he/she had no feeling below the waist and was not aware until he/she noticed his/her shirt was wet. Resident #12 stated, "I raised my shirt and rubbed my hand over my skin and the skin came	F 157	heating beverages and the supervision of residents to include re-heating of liquids to the resident's palatability to ensure their safety and make any needed adjustments to the beverage on 3/18/2011. Current residents with events were reviewed on 03/31/11 by the Director of Nursing Services to ensure physician, resident and responsible party/family notification was completed. No residents were identified. To ensure that the physician, resident and responsible party/family will be notified after an event or change in condition the licensed nursing staff were re-educated by Staff Development Coordinator on change of condition to include physician notification on 3/18/11. To ensure that no other residents will be affected the Director of Nursing, Assistant Director of Nursing and Staff Development Coordinator will conduct weekly audits for four weeks, then monthly audits for two months on physician notification of changes in condition. Identified issues will be	

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F 157	Continued From page 2 off in my hand". An observation of a skin assessment, conducted on 03/16/11, revealed an irregular shaped (approximately 2.5 cm by 1.5 cm) red lesion on Resident #12's lower abdomen. An interview with Licensed Practical Nurse (LPN) #1, on 03/16/11 at 3:50 PM, on 01/07/11 at approximately 8:30 PM, revealed Resident #12 summoned her to the resident's room and told her that he/she spilled coffee on his/her abdomen. She cleaned the burn with normal saline and a gauze pad to get "sticky stuff" off the resident and monitored the resident until the next morning. LPN #1 notified the on-coming shift but did not notify the resident's physician. She stated, "I just didn't call the Director of Nursing. I was trying to give medications and get things done. I didn't call the physician because I just didn't. No one tied my hands, I was new and I just didn't call." LPN #1 revealed she did not complete an incident report because she was new to the facility and did not have the correct identification and password information to access the computer. She passed the information regarding Resident #12 to the nurse who came on duty the next morning at 7:00 AM. An interview with Resident #12's physician, on 03/16/11 at 5:49 PM, revealed she did not recall when she was notified of Resident #12's burn. She also did not recall if she had examined the resident after the burn or what the circumstances were related to the burn. However, she would have expected staff to notify her immediately after discovering a burn. An interview with the Corporate Nurse, on	F 157	corrected upon discovery. The Director of Nursing will report the results of these audits monthly to the Performance Improvement Committee, which includes the Medical Director, Administrator, Director of Nursing, Health Information Manager and Maintenance Director, for further recommendations. Completion date	4/18/11

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F 157	Continued From page 3	F 157		

03/16/11 at 5:58 PM, revealed all three copies of the twenty-four hour nursing logs for 01/08/11 had been torn from the log book and could not be located. She stated the incident with Resident #12 had not been reported to the facility and no investigation had been completed.

An interview with CNA #1, on 03/16/11 at 7:10 PM, revealed Resident #12 requested his/her coffee to be reheated on 01/07/11 around 8:00 PM. CNA #1 stated she reheated the resident's coffee in the microwave for one to two minutes and did not check the temperature of the coffee before giving it to the resident. The CNA went back into the resident's room to answer the call light thirty minutes later and observed what looked like a red whelp on the resident's abdomen. The resident stated to her that he/she had spilled the reheated coffee on his/her stomach. CNA #1 informed the Charge Nurse and was told that the Charge Nurse would take care of Resident #12's wound. The next day a bandage was over the area and no one questioned her about the incident. No one instructed CNA #1 or other staff, to her knowledge, about any precautions for food/beverage temperatures since the incident.

An interview with LPN #2, on 03/16/11 at 8:00 PM, revealed on 01/08/11 at shift change, LPN #1 reported Resident #12 had spilled coffee on his/her abdomen the previous evening. She had cleaned the wound with normal saline and placed a gauze on the area to prevent friction with clothing and bed linens. LPN #2 stated she observed the wound and it looked "red". LPN #2 called the physician to notify her of Resident #12's wound and to obtain treatment information. The physician prescribed Silvadene cream to be

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F 157	Continued From page 4 applied to the wound twice daily. LPN #2 stated she completed the twenty-four hour nurse's report log and placed the pink copy in the drop box of the Director of Nursing.	F 157		
F 253 SS=C	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined the facility failed to ensure maintenance services to maintain an orderly and comfortable interior. Observations of multiple residents' rooms revealed baseboard heaters that were in disrepair and three residents had personally owned window air conditioners because their rooms were too hot at times and the facility failed to provide a window air conditioner to maintain a comfortable temperature. Findings include: An observation, on 03/15/11 at approximately 3:50 PM, revealed heat radiating from baseboard heaters in resident rooms and the air conditioning unit, located in the hall ceiling on the 400 hall, was on and blowing cold air simultaneously. An interview with the Maintenance Director at the time revealed the facility had the original boiler heating system that dated back to the 1960s. Resident rooms had baseboard (radiator type) units that heated the rooms but the temperature	F 253	F253 Resident #16, #17, and #18 were refunded for the cost of the air conditioners by 4/5/11. The Maintenance Director completed an audit on 3/16/11 of baseboard heaters. An agreement was completed on 4/8/11 with Jones and Sons Machine and Welding to complete the identified baseboard heaters repairs by 5/9/11. Maintenance Director completed temperature checks on 3/15/11 in hallways, dining room, and random resident rooms with no abnormal ranges or resident/family concerns of uncomfortable temperatures. Resident rooms were checked for air	

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F 253	Continued From page 5 control was in the boiler room and temperature levels could not be adjusted for individual rooms. Residents who had window air conditioner units frequently had them on in cold weather because their rooms were too hot. In warm weather some resident rooms were too hot because the facility's climate control system was located in the hall areas and not efficient to cool resident rooms. The Maintenance Director stated not all resident rooms had a window air conditioner and the hall air conditioner did not always keep resident rooms comfortable in warm weather and some residents had purchased personal window air conditioners. An interview with the Administrator, on 03/15/11 at approximately 4:45 PM, revealed she had purchased some air conditioning units during the summer season. Review of purchase receipts revealed a window air conditioner was purchased on 06/24/10 and one was purchased on 06/28/10. The Administrator stated one of the air conditioning units was placed in the activity room but could not recall where the other one had been placed. An interview with Resident #16's family member, on 04/16/11 at approximately 9:30 AM, revealed when the weather was warm Resident #16's room was "Hot as Haiti". The family member had asked the facility office staff (couldn't remember who) for a window air conditioner to keep Resident #16 comfortable. He/She was told that the facility did not buy window air conditioners for resident rooms. He/She purchased a window air conditioner for Resident 16's room to keep the resident comfortable. An interview with Resident #17, on 04/16/11 at	F 253	conditioner units owned by other residents and/or families on 3/16/2011 by the Maintenance Director and Business Office Manager. None were identified. The Maintenance Director was re-educated by the Administrator on 3/16/2011 to report any uncomfortable room temperatures or the need for an air conditioner so that it may be replaced. To ensure comfortable temperatures the Maintenance Director or Housekeeping supervisor will complete temperature checks, to include resident rooms twice a week for two weeks and once a week for one month and as appropriate with weather conditions and season changes. Identified issues will be addressed at that time. The Maintance Director will report the results of the audits monthly for 3 months to the Performance Improvement Committee, which includes the Medical Director, Administrator, Director of Nursing, Health Information Manager and Maintance Director for further recommendations. Completion date	4/18/11

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F 253	Continued From page 6 10:10 AM, Resident #17 revealed the resident had resided in a different room at the facility during the past summer season and that room was hot. Resident #17 stated he/she bought a fan in an attempt to keep the room at a comfortable temperature but stated, "It didn't do any good; the room was still hot". The resident requested the facility provide an air conditioner to cool the room but was told the facility could not buy one. The resident revealed that was the reason he/she bought one. An interview with Resident #18, on 04/16/11 at 6:00 PM, revealed his/her room was "Hot and he/she asked family to purchase an air conditioner." Resident #18 stated he/she felt the facility would not provide an air conditioner for comfort.	F 253		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined the facility failed to ensure resident environment was free from accidents hazards as is possible related to one resident (#12) in the selected sample of 15. Resident #12 sustained a burn from a beverage that had been heated in a microwave by staff. Findings include:	F 323	F323 Resident # 12 was assessed by the licensed nurse at the time of the event on 1/7/11 and evaluated. The physician was notified of the event by the licensed nurse on 1/8/11. CNA # 1 was re re-educated by the Staff Development Coordinator on the procedure for heating beverages and the supervision of residents to include re-heating of liquids to the resident's palatability to ensure their safety and make any needed adjustments to the beverage on 3/18/2011.	

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F 323	Continued From page 7 Resident #12 was admitted to the facility on 09/01/2007 with diagnoses to include Spinal Cord Injury of C5-C7, Lack of Coordination, Muscle Weakness, History of Urinary Tract Infections, Diabetes Mellitis, Renal Failure, Paraplegia, and Morbid Obesity. A review of a nursing note entry, dated 01/08/11 at 4:30 AM, revealed Resident #12 spilled hot coffee on his/her abdomen and did not want the nurse to call anyone. The nurse's note additionally stated, "Will monitor and pass to 7-3 nurse". An interview with Resident #12, on 03/16/11 at 3:25 PM, revealed on 01/07/11 at approximately 8:30 PM, the resident requested a cup of coffee be reheated by Certified Nurse Aide (CNA) # 1. The resident stated CNA #1 heated the coffee and brought it back "Scalding hot" and the resident spilled it on his/her stomach. The resident did not realize the coffee had been spilled until he/she looked down and realized his/her shirt was wet. Resident #12 stated, "I raised my shirt and rubbed my hand over my skin and the skin came off in my hand". An observation of a skin assessment, conducted on 03/16/11, revealed an irregular shaped (approximately 2.5 cm by 1.5 cm) red lesion on Resident #12's lower abdomen. An interview with CNA #1, on 03/16/11 at 7:10 PM, revealed Resident #12 had requested his/her coffee be reheated on 01/07/11 at approximately 8:30 PM.. The CNA stated she reheated the resident's coffee in a microwave for approximately one to two minutes. She did not	F 323	Current residents that receive and/or request hot beverages were reviewed by the Director of Nursing on 4/5/2011 to determine if any other residents were affected. The review included assessing cognition, dexterity and assistance level. No other residents were affected. The facility staff were re-educated by the Staff Development Coordinator on the procedure for heating beverages and the supervision of residents to include re-heating of liquids to the resident's palatability to ensure their safety and make any needed adjustments to the beverage on 3/18/2011. The Director of Nursing, Assistant Director of Nursing and Staff Development Coordinator will complete a hot beverage audit 3 times a week for 2 weeks and weekly for 2 weeks, and then monthly for 2 months. The Director of Nursing will report the results of these audits monthly to the Performance Improvement Committee, which includes the Medical Director, Administrator, Director of Nursing, Health Information Manager and	

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F 323	Continued From page 8 check the temperature of the coffee before giving it to Resident #12. Approximately thirty minutes later CNA #1 returned to the resident's room and observed what looked like a red whelp on the resident's abdomen. Resident #12 told the CNA that he/she had spilled the coffee on his/her abdomen. CNA #1 notified the Charge Nurse and was told the nurse would take care of the resident's wound. The CNA revealed she was not questioned about the incident. CNA #1 stated she was not interviewed and had received no instruction since the burn related to precautions before serving residents beverages or food that was too hot and not safe. An interview with Licensed Practical Nurse (LPN) #1, on 03/16/11 at 3:50 PM, revealed on 01/07/11 at approximately 8:30 PM, Resident #12 summoned her to the resident's room and told her that he/she had spilled coffee on his/her abdomen. She cleaned the burn with normal saline and a gauze pad to get "sticky stuff" off the resident and monitored the resident until the next morning. LPN #1 notified the on-coming shift but did not notify the resident's physician. She stated, "I just didn't call the Director of Nursing, I was trying to give medications and get things done. I didn't call the physician because I just didn't. No one tied my hands, I was new and I just didn't call." LPN #1 did not complete an incident report because she was new to the facility and did not have the correct identification and password information to access the computer. She passed the information regarding Resident #12 to the nurse who came on duty the next morning at 7:00 AM. An interview with LPN #2, on 03/16/11 at 8:00 PM, revealed LPN #1 reported to her, in morning	F 323	Maintenance Director, for further recommendations. Completion date	4/18/11

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F 323	Continued From page 9 report on 01/08/11, that Resident #12 had spilled coffee on his/her stomach. LPN #1 had treated the resident's burn with Normal Saline and placed a gauze on the area to prevent friction with clothing and bed linens. LPN #2 observed the wound on Resident #12's abdomen and it looked pretty red. She then called the physician to notify her of the resident's wound and obtain treatment information. The physician recommend Silvacene cream be ordered from the pharmacy and applied to the wound. LPN #2 stated she completed the twenty-four hour nurse's report log and placed the pink copy in the drop box of the Director of Nursing. An interview with Registerd Nurse #1, on 03/16/11 at 5:58 PM, revealed all three copies of the twenty-four hour nursing logs for 01/08/11 had been torn from the log book and could not be located. RN #1 stated the incident with Resident #12 had not been reported to the facility and no investigation had been completed. An interview with Resident #12's physician, on 03/16/11 at 5:49 PM, revealed Silvadene cream had been ordered for the burn. She could not recall when or what the circumstances were related to the burn; however, she would have expected the facility to have notified her immediately after discovering the burn.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources aproved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F371 No specific resident was identified. On 3/14/2011, the Dietary Manager removed and discarded the bent and dented canned goods in dry storage, the drip tray was replaced under the hams and stored according to serve safe guidelines, the mop head was discarded, the grease build up between the wall, stove and behind the freezer and the hair stuck to the corner edge drawer of the prep table was cleaned and removed. The macaroni salad was not served to any residents and was immediately removed from the tray line by the Dietary Manager on 3/14/2011 and replaced with an alternate food. The Maintenance Director will sand and remove the flake and rust from the stove head and replace the floor tiles by 4/15/2011.	

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F 371	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it is determined the facility failed to store, prepare, distribute and serve food under senitary conditions. Findings include: Observations of the dietary department, on 03/14/11 at 11:15 AM and at 4:50 PM revealed the following: 1. Bent and dented cans of tuna were on a shelf with the dry canned goods in the dry storage. 2. One whole ham and one quarter of another ham were being thawed on a shelf with other food items on shelving beneath the hams in the walk in refrigerator. 3. A three compartment sink prep area had a dirty mop head laying beneath the rinse sink. 4. The hood cover over the cooking stove was rusted and flaking, there was a greasy gunk build-up between the wall and the stove and behind the freezer. 5. Floor tiles between the stove and oven were cracked and peeling upwards off the floor. 6. A Dietary staff was leaning over the meat on the steam table and their clothing was touching the meat.	F 371	On 3/31/11 the Dietary Manager re-educated the cook (dietary staff referenced in 2567) on clothing not touching food. On 3/14/2011, a review of the kitchen was completed by the Dietary Manager that included the dry storage areas, process of thawing food items and temperature of food items. The kitchen was deep cleaned 3/14/11 by the Dietary Manager. A deep cleaning schedule and log was initiated by the Dietary Manager on 3/15/11. No residents were affected. The Regional Dietician re-educated the Dietary Manager on deep-cleaning and deep-cleaning logs on 3/15/11. The Dietary Manager re-educated the staff on the storing, preparation, distribution and serving of food under sanitary and safe conditions on 3/15/11. Education included the storing of meats per the Federal Food Safety Guidelines, and proper serving temperatures. On 3/31/11 the Dietary Manager re-educated the cook (dietary staff referenced in 2567) and staff on clothing not touching food, proper disposal of mop heads, hair nets and safe serve guidelines. To ensure the facility will store, prepare, distribute and serve food under sanitary conditions, the Dietary Manager will complete a Dietary Sanitation Indicator	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185012	A. BUILDING _____ B. WING _____	03/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE VILLA CARE AND REHABILITATION CENTER	1600 PRIDE AVENUE MADISONVILLE, KY 42431

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F 371	Continued From page 11 7. Temperatures of the macaroni salad on the tray line was 60 degrees on 03/13/11 at 4:55 PM. 8. The drawer underneath the prep table where cooking utensils were stored, had a large clump of hair stuck to the corner edge of the drawer on both the left and right sides. An interview with Dietary Manager (DM), on 03/13/11 at 11:15 AM, revealed there were no deep cleaning schedule logs kept. She thought the last time deep cleaning of the kitchen was completed was in February 2011. She was unsure as to why a dirty mop head was left under the prep sink. An interview with the DM, on 03/13/11 at 5:25 PM, revealed the Macaroni Salad temperature should be 40 degrees or below.	F 371	audit 3 times a week for 2 weeks, twice weekly for 2 weeks and monthly times 2. The Dietary Manager will report results to the Performance Improvement Committee. The Administrator will complete a Dietary Sanitation Indicator audit twice weekly for 2 weeks, weekly for 2 weeks and monthly times 2. The Administrator will report results of the audits to the Performance Improvement Committee, which includes the Medical Director, Administrator, Director of Nursing, Health Information Manager and Maintenance Director for further recommendations. Completion date	04/18//11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185012	A. BUILDING 01 - MAIN BUILDING B. WING	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE VILLA CARE AND REHABILITATION CENTER	1600 PRIDE AVENUE MADISONVILLE, KY 42431

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted on 03/15/11 to determine Federal compliance with Title 42, Code of Federal Regulations, 482.41 (b) (Life Safety from Fire) and found the facility not in compliance with NFPA 101 Life Safety Code 2000 Edition. Deficiencies were cited with the highest scope and severity of an "E".	K 000	The plan of correction is being submitted in compliance with specific regulatory requirements. Neither its completion nor content is to be construed as an admission by the provider of the validity of any findings or citations contained herein.	
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observations and staff interviews conducted on 03/15/11, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments. This condition affected two (2) smoke compartments, including approximately 90 residents and also staff and visitors. Findings include: A tour of the facility conducted on 03/15/11, revealed the ceiling on the 200 hall medicine storage room behind the nurse's station was noted with approximately 10 communication	K 025	K025 No specific resident was identified. The space surrounding the cables on the 200 hall medicine storage room behind the nurse's station was filled with a material which would resist the passage of smoke on 3/18/2011 by Maintenance Director. An audit was completed in the building by Maintenance Director on 03/21/11 to determine if there were any openings in smoke partitions that would not resist the passage of smoke. Identified areas corrected at that time. No residents were affected. The Maintenance Director was re-educated on the NFPA 101 Life Safety Code regarding smoke barriers that would resist the passage of smoke between smoke compartments by the Administrator on 3/21/2011	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carol L. Britt
TITLE: Administrator
(X6) DATE: 04/09/2011

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185012	A. BUILDING 01 - MAIN BUILDING 01 B. WING	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 025	Continued From page 1 cables through a 1-1/2 inch hole. The space surrounding the cables was not filled with a material which would resist the passage of smoke. An interview with the Maintenance Director, on 03/15/11 at 11:15 AM, revealed he was aware of the fire code requirement but had overlooked the lack of sealant around the conduit in this particular room. Reference to: NFPA 101 Life Safety Code 2000 Edition 8-2.4.4 Penetrations and Miscellaneous Openings in Smoke Partitions. 8.2.4.4.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through smoke partitions shall be protected as follows. (1) The space between the penetrating item and the smoke partition shall meet one of the following conditions: a. It shall be filled with a material that is capable of limiting the transfer of smoke.	K 025	The Maintenance Director or Housekeeping Supervisor will complete a facility smoke partition audit once a week for 4 weeks and once a month for 2 months. The Maintenance Director will report results to the Performance Improvement Committee,, which includes the Medical Director, Administrator, Director of Nursing, Health Information Manager and Maintenance Director for further recommendations. Completion date	4/18/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185012	A. BUILDING 01 - MAIN BUILDING B. WING	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE VILLA CARE AND REHABILITATION CENTER	1600 PRIDE AVENUE MADISONVILLE, KY 42431

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carol L. Britt
TITLE: Administrator
(X6) DATE: 04/09/2011

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	185012	A. BUILDING 01 - MAIN BUILDING 01 B. WING	03/15/2011

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